"IMPROVEMENT OF ACCESS TO MENTAL HEALTH SERVICES AMONG MOST AT RISK POPULATIONS
IN GREAT CAIRO (Cairo and Giza governorates)"

FULL PROPOSAL
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IN GREAT CAIRO”

November 2012 - October 2015

FULL PROPOSAL

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PROJECT’S CONTEXT AND ANALYSIS

MdM Mission in Egypt

Médecins du Monde-France is present in Egypt since the end of 2004.
It implemented and completed one project: "Access to Reproductive health care for girls living in the streets of Cairo" (2005-2008). The project has been funded by the European Union and Drosos Foundation.

From 2009 to April 2012, Médecins du Monde-France has implemented a project to improve health care access for children in street situation: "Health right promotion for Children in Street Situation in Great Cairo", funded by Drosos Foundation.

The implemented projects mentioned above, clearly showed that children in street situation are suffering of specific mental health distress due to their marginalized and at risk living conditions.
As well the discussions with NGOs, and other experts in the field underlined not only the specific needs on mental health for vulnerable population, but as well the lack of efficient services in the community, and at the level of primary health centres.
Threfore, Médecins du Monde team in Egypt has carried out interviews with some key health professionals in the specific field of mental health and primary health care, we mention Dr Azza Dessouky, GM of the PHC department in the MoHP and as well the director of Child and Adolescence Unit for the General Secretariat of Mental Health, Dr Maha Emad; as well the director of the general secretariat of mental health, Dr Khoweiled and Internatianl affairs responsible, Dr Sourur(MoHP); WHO-EMRO advisor for mental health and susbstance abuse; representatives of civil society (NGOs); and professionals.
Such meetings, added to the literature review analysis, brought about some interesting aspects where Médecins du Monde would be effective and bring an added value.

Firstly, what clearly emerge is the presence of a strong will by the Egyptian MoHP to decentralize mental health services, from the city level (mental hospitals) to district (primary health care/ family health model) and community level (the community itself).
The decentralization process will permit the patients and their families to have a close-to-home, and more friendly access to mental health care in PHC centres; it will as well help to set up an efficient reintegration to the society, through the involvement of the community actors, such as NGOs and community leaders.
Secondly, it emerged the importance to focus on providing better training for not only health professionals but as well social workers and nurses PHC centres and health visitors, having considered their crucial role within the community.
Thirdly, stigmatization in health facilities and community environments emerged as an important obstacle for a better understanding and acquiring information and skills for supporting the rehabilitation and reintegration of vulnerable populations.
Considering the impact of the consequences of mental health distress, not only on the patients themselves but as well in the society, and the lack of a decentralized system for MH services provision, Médecins du Monde considers the importance to carry out an intervention to better integrate the MH services in Primary Health care and the community, in order to contribute to an effective comprehensive PHC Family model and health access in the most vulnerable areas and populations.
An effective PH integration and a stronger community involvement will permit an adequate preventive and care support for marginalized and at risk populations, and ensure an effective reintegration in the society.

Problem description and project justification

Following WHO data, neuropsychiatric disorders represent 14% of global burden of diseases in the world and 12% in Eastern Mediterranean WHO area (including Egypt).

In 2009, a national survey of prevalence of mental health disorders in Egypt, estimates this prevalence at 16,93% of the studied adult population (main problems were identified as mood disorders, anxiety disorders). These disorders were associated with socio-demographic factors (for instance being female, and being unemployed) and physical illness.
In Egypt, the populations most at risk of incurring in mental distress are: women victims of violence, disadvantaged children, prisoners, and persons with disabilities. Adolescents, are as well affected specially male (with problems of substance abuse) and femame (with problems of physical abuse). Finally, people living with HIV/AIDS and hepatitis C are as well affected by mental distress.
Not only the at risk population incur in mental distress, but as well their families, especially of children with disabilities.

Mental health services in Egypt are managed through two main systems under the MoHP: the general secretariat of Mental health that supervises a total of 19 hospitals; and 13 mental health departments in general hospitals, plus 62 outpatients clinics, managed by the Curative department of the MoHP.
Out of the 62 outpatients clinics, only 2 are dedicated to children and adolescents; only one clinic provides follow-up care in the community, and one has a mobile team, and in general psycho-social approach is not used.
In general, outpatient clinics receive referrals from the primary health care, but there is a lack in feedback and communication which affects the follow-up care, moreover there is no outreach and home based rehabilitation system, or community rehabilitation centres.

Psychotropic drugs are available in mental hospitals, and in outpatient and inpatient clinics, while they are not available in primay health centres.

Mental health services are present in the main Egyptian big cities, but they lack in slum, or remoted areas.

Regarding human resources, the distribution of mental health professionals between urban and rural areas is disproportionate, and it sees mainly psychiatrists and nurses in urban mental health hospitals, then in outpatient clinics.

In Primary health care centres, mental health training has been provided to a 5% of doctors, 1% of nurses, and 6% of social workers; moreover, less than PHC have assessment and treatement protocols of mental health conditions.

Finally, in Egypt, only 9% of the Health budget is dedicated to mental health activities.

Despite a strong government will of decentralization of mental health services at primary health care level, still Primary health centres staff is not yet prepared to provide mental care to patients.

Main challenges in accessing mental health services and and most at risk population

Main challenges assessed in the field of mental health care and support to marginalized populations, like victims of violence, children living in the street, people living with HIV/AIDS, and persons with disabilities, are the following ones:

- No adequate integrated services and support programmes at the community level, for instance in the NGOs supporting vulnerable and at risk populations;
- Lack of mental health care services at the Primary Health Care level, and above all in marginalized and deprived areas;
- Widespread stigma around the concept of mental health and towards persons suffering of any kind of mental health distress;
- No existence of a platform for exchange and dialogue among non-state actors, families networks, patients, health and social practitioners and local authorities concerned by mental health issues.

As previously mentioned, the needs in the field of mental health care access become more obvious and strong when affecting vulnerable and at risk populations, living in marginalized and deprived areas.
Greater Cairo (for this project, Cairo and Giza governorates) has been experiencing in the last twenty years a sudden and not systemized urban growing, that caused the creation of informal and "forgotten" areas that are not served as the rest of the city. Poverty, hard and insecure living conditions in such areas are key elements for mental health distress to take place, especially among persons who are already more vulnerable than others.
In such areas, lack of occupation, loss of jobs, precarity, presence of chronic dise ases, diffuse violence (inside or outside the families), and insecurity are important causes for mental distress to further exacerbate the lives of at risk populations.

Most at risk populations living in these areas do face more difficulties in access to good services and in finding the support of the community they live in:

Women who face any kind of violence (physical, sexual, psychological, or economic violence) do suffer of important consequences affecting their entire life that can lead to physical injuries, sexual and reproductive problems, and to psychological and behavioural outcomes.
In the specific Egyptian context, it often happens that due to the economical, social and cultural factors, women tend to not inform about abuses because of fear of the consequences. The management of psychological disorders in women lacks in effectiveness, and health professionals tend not to detect abuses, and to minimize or ignore reports of abuses.
This approach will therefore encourage the perpetration of violence, with consequences not only on the woman herself but her family and children too.
Legally, some decrees and laws that would protect women from violence have been presented and approved, nevertheless their fully implementation is far from being applied.
The project will work both on a preventive and curative approach, involving social and medical staff (from NGO and health care centre) in providing an integrated mental health care; it will also work on raising awareness and advocacy on the consequences of violence on women, on the right to receive support and adequate care, through a participatory approach with community actors.

In Cairo, **children in street situation** live in an extreme challenging environment, where no mechanisms of child protection are in place.
Their physical and mental conditions are constantly at risk. Girls living in the streets face the following risks: violence, abuses, drugs use. The consequences vary from post traumatic disorders, depression, anxiety,low self esteem, addiction and self mutilation acts.
The Egyptian Child Law and its recent modifications, plus other recent decrees protecting all children without any form of discrimination, have been presented to the Parliament but there is still work to be done in increasing awareness and in applying them fully.
MdM has a wide experience in working in street children health, protection and already started a work on mental health, that worth to be continued. As for the rest of beneficiaries, it will include a preventive and curative approach through the services provided by the NGOs and health care centres, and an awareness and advocacy plan that will be carried on by the community actors, and professionals.

In Egypt 3.4% of the populations has a **disability**, and 25% is affected indirectly as family members and caregivers of disabled persons.
The figures are not defined, because due to stigma, people prefer hiding the presence of a disabled person inside their family.
The facilities available to cover the needs of people (and in specific children and youth) with disabilities are covered only for 10%.
What is necessary to develop is not only providing the services to the persons with disabilities, but as well to create a friendly environment that supports the families of the patients. Secondly, persons with disabilities need special care for their mental status, as they generally experience mental distress (like depression) when isolated, ignored and marginalized by their peers, or community.
Disable people and their families face difficulties in accessing services, due to lack of trained social and medical staff; to the stigma and negative attitudes spread in the communities; no adequate friendly structures.
The project considers the importance to support the persons with disabilities and their families, providing not only services but as well a platform for exchange.
Moreover, awareness activities will involve the beneficiaries directly; and finally an advocacy strategy will support the work already initiated on law for persons with disability.

For **people living with HIV/AIDS, or persons at risk of being infected with the virus**, like persons with substance abuse disorders, or risk behaviours, psychological distress is evident, in forms of depression and anxiety. Generally, and in the specific Egyptian context, people infected by the virus face a high degree of stigmatization, and might as well loose the support of friends and family.
Some NGOs in Egypt provide HIV testing and counselling services, nevertheless the stigma in the society is so strong that hampers the provision of adequate integrated care services to the patients, and support for their families.
Besides the stigma, another factor affecting the provision of adequate integrated care is the lack of skills among health care professionals in assessing, managing and referring cases.
The project considers the importance to work on prevention for the persons at risk, and on providing the skills to health and social professionals to deal with the mental distress the patients might face, and as well to refer cases.
As much as authorities will permit, the project wishes to support advocacy on the rights of all patients to receive adequate care.

Geographical location

Médecins du Monde, through the previous projects experience and collaboration with local NGOs, has acquired good knowledge of the socio-geographical areas that will be targeted by this project, and as well with part of the beneficiaries (children in street situation).
In specific, the project will focus in the areas where the NGOs partners and the Health care centres are located:
Old Cairo, Sayda Zeinab, el Fustat area, Hezbat el Haggana, Bulak Dakrour, Embaba. These areas are all characterized by being poor, densely populated, slums and deprived areas.

Partners in the project

The action will have important and varied resources in order to achieve the above mentioned changes.
Such resources consist in the technical capacities, either knowledge or field work experience, or networking skills of local partners, associates and target groups.
Concerning the stakeholders, as we have mentioned in the concept note, the project will be implemented with an effective participation of six Egyptian NGOs, the concerned local authorities, and independent professionals.
MdM chose to work with these NGOs for their experience in the field of development, of support to most marginalized persons, for their known reputation by the people of their community. The above factors will guarantee an easy and natural access to the beneficiaries of the project, who are already benefiting of the services provided by the NGOs.
MdM has selected 5 NGOs, and it is under the process of identification of the 6th partner that will focus on disabilities issues.

Operational partners

The NGO **Cewla**, (founded in 1995) located in Bulak el Dakrour, has a long and solid work experience in providing legal support for **women victims of violence** and advocate for women's rights.
CEWLA's activities achieved an important impact in dealing with legal issues, empowering marginalized women and fighting violence against women and human trafficking. It is considered as one of the pioneer organizations in Egypt to work in the field of trafficking.
MdM recognizes important aspects of the NGO, the high reputation in the area among women beneficiaries, their work approach based on building the capacities of other associations and as well on lobbying for legislative reforms. As well, the NGO does an effective work on advocacy based on Networking.
Within the project, Cewla will have an active role together with MdM and the rest of the NGOs partners in carrying out the awareness and advocacy strategy, in organizing with the health care centres health education sessions, in providing services within their NGO. Its staff will attend a series of training sessions on mental health main disorders, and as well the NGO will provide its premises when necessary, and the availability of two key persons. Moreover, Cewla has a shelter to receive trafficked victims and violated women.

The NGO, **El Shehab for Comprehensive Development, (**founded in 2001), is located in Hezb el Haggana, an informal settlement of hundreds of thousands inhabitants.

The NGO has a long experience in empowering marginalized groups like **women, children and youth**, through community participation and decentralization of decisions making initiatives.
The NGO El Shehab, with their mission of empowering the people living in slum and deprived areas, and their experience on programmes to support women, children and youth will bring an added value in the project.
Their main programmes focus on: defending residents the rights to decent housing and basic services; women empowering; and as well health promotion on at risk behaviours of vulnerable populations; child rights protection with children at risk and street children.
MdM considers the multidisciplinarity of their programmes and themes an important factor for collaboration, moreover their actions are well know and trusted by their community, and they are considered as a referent point for social, economical, legal and education aspects by the inhabitants of this area. The project will surely involve the group of volunteers dedicating their time to El Shehab activities.
El Shehab will be involved like the rest of the partners in carrying out the awareness and advocacy strategy, in organizing with the health care centres health education sessions, in providing services within their NGO. Its staff will attend a series of training sessions on mental health main disorders, and as well the NGO will provide its premises when necessary, besides the availability of two key persons.

The NGO **Banat el Ghad**, (founded in 2010) located with two day care centres in Embaba and Old Cairo and one permanent shelter in 6th October, has the main scope to support **girls in street situation**, through a comprehensive approach, where social, educational, legal, and psychological services are provided, and well structured rehabilitation and health care support.
MdM chose to work with this NGO for different reasons: first of all, MdM already worked with them in the previous project supporting CSS and there is a reciprocal strong satisfaction of the work done together; moreover, we consider that their involvement in advocacy issues is vital, and as well their human resources have a good expertise in the field of mental health, besides motivation and initiatives taking approach.
For this project, MdM believes that big part of the work should focus on the girls attending the day care centres, because in general they are in need of stronger psychological services.
The NGO will carry out the project activities of awareness and advocacy, plus they will attend the training sessions, they will coordinate with the health care centres the health education activities, they will be responsible in providing specific mental health services and activities within their NGOs, and they will appoint two key persons to supervise all the field activities.

Basmat Amal is a NGO (founded in 2000) located in El Manial el Roda and Seyda Zeynab.
The NGO was created through the initiative of a group of parents of children with disabilities.
The small size association delivers services for children with disabilities though a well trained staff; as well they support the families of the children; and they work finally with the community in raising awareness on what is disability, its consequences, and the needs of persons with disabilities.
As well, the NGO works within a network on advocacy for the rights of persons with disabilities.
MdM considers the above mentioned aspects (the services delivered, the community awareness and the advocacy) of importance for the project objectives. Their experience in the field of disabilities, and as well the families network they have developed in the last years of work is the added value they bring inside the project.

Their staff will have the possibility to attend specific mental health training; they will collaborate with the health centres in organizing education sessions for the community; and they will participate and organize the awareness and advocacy activities.

Finally, another important resource NGO that will be involved in the project is **Waay**, in English “Psychological health and awareness society in Egypt” **(PHASE)**, (founded in 2006); they have 70 active professionals members. They provide for most vulnerable populations: counselling and treatment for patient suffering from psychological disorders and particularly those suffering from trauma (abuse, domestic violence) and addiction; carry out prevention and community awareness programmes, develop training for psychosocial teams, for teachers, doctors and nurses and finally they focus on research.
PHASE works through three core channels: treatment, education and information, with the objective to increase awareness and better health care for psychological and psychiatric conditions.
MdM sees the involvement of Waay two-folded.
First of all the project will have the possibility to strengthen the activities already carried out by Waay on prevention, treatment, referral and advocacy for people infected and affected by HIV/AIDS, or at risk people. This will be an important possibility to work on mental health support for this population, through the previous work already done by Waay.
Secondly, Waay will in some cases or moments of the project collaborate in providing mental health expertise, as consultants for writing some training packages.
PHASE members have expertise and field experience in the areas of providing psychological and psychiatric treatment to individuals and groups who have been exposed directly or indirectly to violence under its multiple forms, psychological or physical.

Institutional partners

As for the institutional partners, MdM considers essential to work with the local authorities concerned with the project thematic, directly or indirectly.
In specific, the General Secretariat of Mental Health and the Primary Health Care Department, have already been involved in international programmes on community mental health and integration of mental health services at primary health care level. They do therefore already have knowledge of the intervention processes; in particular they both have specific human resources already available for coordination and communication aspects. The collaboration in the project will be defined by an agreed upon Memorandum of Understanding between them and MdM that sets clear objectives of the collaboration and roles for each actor.
As well, the concerned national Councils for the populations and thematic tackled in the project, will be included in the project activities, and specifically in the advocacy and networking initiatives; these are the national Council for Mental Health, the national Council for Childhood and Motherhood, the national Council for Disability Affairs, and the national Council of Women.

PROJECT DESCRIPTION

Target groups and beneficiaries description

As we have clearly expressed in the concept note, the project will influence the following:

Mental health care access, more than physical health care becomes an obstacle when the patients are already considered as vulnerable or stigmatized group, and means, knowledge and services provision is insufficient and lacks in quality.
Within MdM mandate of supporting those whose the world is gradually forgetting, the project wishes to target as final beneficiaries the following:

Target groups, who are involved in carrying out the project activities and will benefit of the final results of the action.

- People suffering of mental health disorders and their families, who will benefit of the destigmatization campaigns and advocacy actions, and as well by better services provided in their community;
- Egyptian civil society working with vulnerable populations, who will reinforce its capacities to address mental health problematics within its different actions (NGOs);
- Professionals working at primary health care centres, whose role will be reinforced and valued (PHC centres);
- Egyptian health authorities, who will benefit from pilot implementation of the mental health decentralization policy.
- Community actors in specific neighbourhoods of Greater Cairo, like religious leaders, school teachers and social workers.

Direct beneficiaries, who will benefit of the services/activities of the project.

Populations particularly vulnerable to mental health disorders living in slum and popular neighbourhoods of Cairo, and their families.
Poverty and hard living conditions in slum and under-served areas are key elements for mental distress to take place, and especially among persons who are already more vulnerable than others. In these areas, lack of occupation, loss of jobs, precarity, presence of chronic diseases, diffuse violence and insecurity are important causes for mental distress to further exacerbate lives of at risk populations.

The direct beneficiaries are:
- Women victims of violence; in 2005, Egypt Demography and Health Survey estimated that 47% of married women suffered physical and psychological violence since the age of 15.
- Children in street situation, who are estimated by the local actors to be several tens of thousands in Cairo.
- People living with HIV/AIDS and people at risk, i.e affected by substance abuse disorders, who face various forms of psychological distress due to their condition (chronic disease, stigma, difficulties due to treatment);
- Persons with disabilities; the psychological impact of a physical and/or mental disability is rarely taken enough in consideration by medical staff, and not enough awareness among the community is carried out.

	TARGET GROUPS AND DIRECT BENEFICIARIES				
	NGOs staff	**PHC staff**	**Direct beneficiaries/MARPs**	**Community actors**	**Authorities**
PROJECT FINAL REACH	**24** (1 IEC person, 1 focal point, 2 social workers for	**56**	**2520**	**2520** (includes family groups, school teachers,	**160** (see result 2 activity 5)

	each NGO) (6)			community and religious leaders, youth clubs members) participating in or attending: health education sessions, mental health awareness sessions.	

Objectives, Results and Activities

It is worth pointing out that in each activity of the action, the actors involved (operational partners and institutional governmental partners) will be participating and having specific roles according to their expertise, to their needs, to their possibilities and availabilities.
The group of actors involved naturally have their own specificities, structures and methods, and set of mind; the intervention wishes to integrate all these different and enriching skills, knowledge, experiences in an harmonized and smooth collaboration, focusing on its main scope, which is the global action objective.
The partners won't participate to all the activities with the same level of involvement, but according to previously agreed roles and expertise.

It is important to remind again the general and specific objectives of the action:

The general objective is the following one:

"Improvement of access to mental health services among most at risk populations in Greater Cairo"
The action will focus at enhancing mental health care access at the level of Community and Primary health care services.

The specific objectives are the following ones:

The intervention has set 3 specific objectives that are expected to achieve results through the implementation of activities, mainly focused on capacity building, anti-stigma community activities, networking and advocacy.
We wish to remind though that the action activities will not run isolated from the regular activities that the partners daily implement in their community, but they will be integrated in such activities through a complementary and comprehensive approach, which can be considered as an holistic approach, where health and social needs are met together.

Objective 1: Mental Health services are available and effective in 7 PHC centers in Cairo

Result 1: The system is organized to introduce mental health activities inside the 7 PHC centres

Activity 1: Organization of a referral system

- Organize the visits of the primary health facilities staffs to the mental health hospitals.

- Organize workshop and coordination meetings between mental health hospital staffs and primary health care staffs to improve the referral system.
- Create a contact list and improve the feed-back to the primary health care centers

The first part of activities will focus on developing an efficient and easy referral system, which today does not exist in Greater Cairo, and such a lack of referral system and of communication between health providers affects negatively care access for vulnerable populations.
Main actors in the development of the referral system are:
The staff (a team of 2 doctors, 2 nurses, 2 social workers, 2 health visitors for each center) of 7 PHC centres, who will visit mental health hospitals; they will participate in workshop sessions, and coordination meetings with the staff of mental health hospitals;
As well, key identified doctors and nurses of mental hospitals will participate at the workshop sessions, to brainstorm ideas on how the ideal referral system should be;
Both staff of primary health care centres and mental hospitals will be the ones developing the referral system, and share it with all the target groups, and final beneficiaries.

Time: at the end of the first year, the referral system is ready and distributed.
Target groups and beneficiaries:
Total of 14 doctors, 14 nurses, 14 social workers and 14 health visitors from the 7 Health care centres.
Total of staff of 2 Mental Health hospitals: 5 doctors, 5 nurses and 5 social workers.
Coordination meetings/visits per year: 6 meetings/visits/work sessions.

Activity 2: Introduction of Mental Health as part of Family Health model in PHCC

- Create a Mental Health sheet to be integrated in the family folder.
- Plan on a regular basis the presence of a psychiatrist to give specialized consultation for patients

According to MdM assessment in the health care centres, the medical and paramedical staff, although showing interest and motivation in caring for patients with mental distress, argued that in fact there is no time left after their tasks for such a further commitment; besides, the centres lack in a complete Family folder file.
MDM team will support, in collaboration with the primary health care department, the development of a mental health file that will be distributed in other family health centres;
Moreover, the general secretariat of mental health will support the “recruitment” of motivated psychiatrists to carry out consultancies once a week in the health units.

Time: the mental health file will be ready at the end of the first year;
Time: presence of one psychiatrist in 7 health centres, after the 5th month.
Target group and beneficiaries: Total of 70 consultations for direct beneficiaries per month (10 per each Health centre). Total per year: 840 consultations each year, for direct beneficiaries.
Creation of 1 mental health folder, plus 1 referral list, to be used during the project by 7 health care centres, 2 mental health hospitals (and other mental health facilities), and 6 NGOs.

Activity 3: Equipment of rooms and/or renovation of existing consultations rooms in PHC centers.

In the first couple of months of the project, further visits and assessments in the health care centres will be carried out. Under the supervision of MdM team and other professionals, the needs for each centres will be verified so as to ensure a comfortable and friendly space where the psychiatrist will carry out the consultations.
In each centre, the manager will be monitoring and supervising how the space has been used properly.

Time: renovation or equipment of consultation rooms during the 3rd month of the first year.
Target groups: 7 health care centres staff (14 doctors, 14 nurses, 14 social workers, 14 health visitors), and the patients who come for consultancy (840 total per year)

Result 2: Health professionals, Health workers, Social workers, and community visitors of 7 HCC in Cairo improved their skills and knowledge on mental health and apply it

Activity 1: Training of Health Professionals of 7 PHC centers on Mental Health diseases, psychotherapy techniques and psychiatric drugs (including therapeutic education)
-To strengthen the knowledge of the PHCC staffs on therapeutic indications, interactions and side effects of psychiatric drugs (work on the basis of the national mental health guidelines)
-Strengthen and/or introduce the skills of non-pharmacological interventions (listening, psychotherapy, addressing social factors, and training of family…) in the PHCC to allow the better follow-up of patients.
-Plan on-the-job training after training sessions to improve the follow up of trainees

The part of capacity building starts with providing the medical doctors, nurses, social workers and health visitors in each of the 7 health centres on specific subjects related to mental health disorders. What has been assessed is that almost none of the medical and paramedical staff met in our visits has ever received a training package on mental health and no services are available in their centres, although some of the doctors and nurses and social workers have some ideas of most common mental distress and its causes in the community.
Therefore, capacity building is one of the first need to be covered.
It is important to notice that the curriculum of the training sessions aims at answering the needs of the community where they are located, and the NGOs will help directly in adopting a final curriculum, reporting the results of focus groups with their populations target, that needs to be carried out in the very first month and half of the project.
This means that each health centre staff will attend a core common set of training sessions on most common mental health issues, and a more specific set of sessions according to NGOs target population needs.
Therefore, the role of the NGOs partners will be to organize and supervise with MDM team the “focus groups” with the target populations; one of the NGO partner, Waay, will be responsible in analyzing the results of the focus group and develop an adequate curriculum, to be shared with PHC department and General Secretariat of mental health.

Time: Focus groups, 2nd month of the project.
Time: Results analyses, development of curricula for each centre, identification of trainers (3rd month)
Time: Training sessions for medical staff will begin on the 4th month.(4 sessions/subjects the first year; and 5 sessions/subjects the second year; 2 sessions in the third year)
Target groups: Each year 14 medical staff in the health care centres is trained.

Activity 2: Training of Social workers and Health visitors on social aspects of psychiatric diseases
(Screening, awareness, follow-up of patients, communication skills, therapeutic education and Training of trainers)

For this activity, we can refer to the description given above for the Activity 1, and as well time wise, the two activities will run in parallel, but of course with a different methodological learning approach and different topics to be tackled in the training sessions.
Social workers and health visitors are the professionals who are more in contact with patients, with their stories, and their life environment. As they are the ones in general most trusted and the ones people refer to in general, we believe that it is necessary to focus the training sessions on more practical aspects in order for them to be able to screen possible cases of mental distress (or through their work in the centre, or through visits at home), to be able to effectively communicate with patients and families on how to reach the patients and follow-up their cases.
Furthermore, it is necessary to empower the function and position of social workers, health visitors, to play a better and more visible role and therefore, they will learn and then apply in their work alternative therapeutic techniques/education with patients; finally, they will receive a ToT in order to be able to transfer the new skills and knowledge to their colleagues.

Time: Focus groups, 2nd month of the project.
Time: Results analyses, development of curricula for each centre, identification of trainers (3rd month)
Time: Training sessions for social staff will begin on the 4th month.
Time: ToT session beginning of second year
Target groups: Each year 24 social staff in the health care centres is trained.
24 social staff will receive a TOT.

Activity 3: Participation in updating and distributing the existing Mental Health guidelines

As described in the previous chapter, MDM wishes to support the MoHP in updating and distributing the guidelines.
In fact, the work will be a collective effort of different professional actors (WHO substance abuse department, MoHP, PHC department and General Secretariat of mental health. MDM will support the printing process and supervise the awareness/training sessions that will follow the distribution, with the help of the health care centres staff.

Time: Half of second year.

Impact of the achievement of the objective on the beneficiaries

Women victims of violence, children/girls in street situation, people living with HIV/AIDS, persons with substance abuse disorders, and finally persons with disabilities will have an easier access to mental health services inside their community. In case their health status is challenging and in need of more specialized services, the patients and their families will benefit of a comprehensive referral system that is easily accessible to all. In specific, the vulnerable populations will be able to receive not only services, but as well clear and basic information and counseling, through the presence of a specialized doctor (a psychiatrist) in the health centre; they will also find a friendly and comfortable atmosphere, and they will benefit of a constant follow-up of their cases.

Furthermore, key community actors, like the families of the patients, religious leaders, school teachers and finally the NGOs partners staff will benefit of the presence of mental health services in the health units/or other public health centres located in their area, without the need to transfer their relatives, patients/clients to unknown, and sometimes unfriendly hospitals or institutions.
Finally, and most importantly for this objective is that health professionals (doctors, nurses, social workers and health visitors) of 7 Primary health care centres will increase their skills and knowledge about mental health issues, and their role and value in the community, and even at wider level, will be reinforced and more visible. Their role and value enhanced, their motivation will be higher and it will reduce the usual turn-over of medical staff in health centres.

Objective 2: Capacities of the civil society to work with vulnerable population are improved

Result 1: Capacities of local NGOs to respond to mental disorders are strengthened

Activity 1: Training for the staff of the partner NGOs on mental health disorders, counseling; referral system; in providing awareness sessions on MH to the community leaders; training in animating focus groups

As mentioned, the intervention wishes to have an holistic and comprehensive approach, and this would be possible when health and social professionals possess useful knowledge and skills to deal with vulnerable populations of their community, without the need to refer to specialized and centralized structures, where most of the time is not possible for lack of financial resources, for being located away from the community and for the high stigma and prejudices around what is mental distress and mental hospitals.
Specific NGOs staff concerned with field work, such as social workers and/or psychologists, according to the size, activities and possibilities of each NGO partner will attend practical training sessions, according to their needs, that have been agreed upon in the first month of the project, through a “workshop on training needs”. As the training curricula for the health centres staff, the training package for NGO staff will include a core set of common mental health topics, and as well more specialized topics according to the needs of the target population.
For instance: Cewla and El Sheab team training sessions will focus on women issues and also on children and youth at risk; while Banat el Ghad training sessions will focus on specific issues of children living in the street; New Horizon and Basmat el Amal will focus on disabilities issues; and finally Waay will focus on issues related to people living with HIV/AIDS.
In general, the staff of the NGOs will receive skills that will benefit to the target population (counseling, focus group animation, referral system application, and some more specificities) but they will also acquire skills on how to organize awareness sessions to community leaders.

Time: 1st month, “workshop for training needs” of NGOs.
Time: 4 sessions/subjects/first year; 5 sessions/subjects/2nd year; one session in the third year.
Target groups: each year 24 social workers of the NGOs will receive a training package;

Activity 2: Coordination meetings with the PHC center’s team, and MH hospitals.

As already mentioned in objective one result one, it is necessary in order to create an effective referral system to have a regular exchange of information, data, experiences between NGOs/community, health care centres and mental health hospitals. In fact, through regular coordination meetings, the referral system will not only be more efficient, but it will also enhance a better take in charge of many health care issues of the population. Finally, those regular coordination meetings will also have the objective to monitor the project activities and create a space for open discussions.
Staff of NGOs, together with health care centres staff, representatives of mental hospitals will attend a coordination meeting every two months. Each time, one of the NGO staff will lead the meeting, preparing the agenda, writing and disseminating the minutes, with the support of MdM team. This active participation will guarantee the sustainability of the action in the future, once the project is finished.

Time: 1st meeting will take place on the 3rd month. It will take place every two months.
Target groups: Every two months a coordination meeting with the attendance of: 7 NGO representatives, 2 representative of PHC department, 1 representative of Mental health hospital, MdM representation.

Activity 3: Participation in Health Education sessions and in the social activities of the PHC centers.

During MdM assessment in health care centres, it was noticed that a useful way to transfer messages to general population about different health issues is the weekly health education session that takes place inside the health care centre. In general, main topics that have been discussed till now are family planning subjects. Therefore there is a need to discuss about more issues that are as well important, and that affect life patterns of persons. In general, these health education or social activities are organized by the nurses.
Through a good project collaboration between the health staff and the social staff of the NGOs, these health education sessions could benefit much larger population, and as well will tackle issues related to psychological distress and other thematic, according to the needs.
The regular coordination meetings will be the chance to set a monthly programmes and subjects, for the health education sessions. Health centres nurses with the NGO staff will set the programme, will coordinate the sessions together and will follow-up the sessions, with the support of MdM team.

Time: During the first coordination meeting (on the 3rd month) an health education programme session will be prepared, and it will take place once a month.
Target groups: community actors, plus families, plus patients will attend once a month.
Number of monthly attendance: 70, total per year 840 attendees.

Result 2: Vulnerable people suffering of mental distress are supported by the communities and the Health System in Cairo

Activity 1: Creation or strengthening of a network of patients families.

According to MdM assessment among civil society actors, families of patients go across different kind of obstacles when dealing with the health of their dears for some of the follow reasons: first of all there is a vast lack of knowledge and taboo when talking about any health problems that is not physical. Even when the knowledge is present, the presence of quality services and prepared personnel is another challenge; and finally during treatment, families find themselves alone, without being prepared on how to deal with the problem, and without any moral support.

The intervention therefore will create or reinforce informal network of families with the objective to: discuss policies for improving health care services, to better integrate in the society vulnerable population suffering from different mental health distress, and to better define needs and solutions as carers. Of course, the reintegration in the community will consist in the activation of the already existing activities of the NGOs partners, either education reintegration, or social reintegration or helping in looking for job opportunities. This activity will be carried out through the participation of the staff of NGOs and community leaders as well.

Time: at the end of the first year, the network of families starts to meet regularly.
Beneficiaries: the network will be finally composed by an active group between 10 and 20 members.

Activity 2: Awareness of the communities on Mental Health distress and solutions (NGOs, community and religious leaders, schools, youth clubs) through radio programs and/or theater activities and/or seminars (still a range of other activities can be discussed).

This activity, like in general all the activities of objective 2, wishes to be a de-stigmatization process.
Stigma around mental health issues affects a clear understanding of the problem, and as a consequence affects a correct take in charge. Therefore, the choice to carry out activities of awareness and sensibilization of the entire community and society is extremely necessary in order to create a fertile and prepared ground to start to work from.
For instance, the intervention might consider different approaches and terminology to reach different communities or a larger audience.
In this process, the active and frontline role of the target groups is fundamental, as they are part of the change of the set of minds of people, and they will not be only services users. The anti-stigma initiatives proposed are considered as well as a rehabilitation therapy, helping the persons to feel better, and to express their ideas, opinions about different subjects. For instance, activities proposed are theatre workshops and performances, a radio programme, and seminars.
In all the three mentioned activities, the target groups will have the main role, with the support of the staff of NGOs, MdM team, families. For each case, according to the situation of the target group, the activities could be adapted; maybe some NGOs will focus on the three activities, while other will focus only on one of them.

Time: from the 8th month/first year, first anti-stigma activity.
Target groups and indirect beneficiaries:
3 Theatre workshops, plus one final performance: 30 participants each time.
2 radio programmes: each on line session will contain 10 stories. Total of 20 stories.

Activity 3: Discussion groups for the patients in PHC centers and NGOs.

This activity consists in a service provided for the beneficiaries, whom they will benefit either in the health care centre or in the NGOs premises. In different mental health programmes already carried out in Cairo, it was underlined that in general, discussion groups are not well or enough organized, while in fact they are very useful for the patients as a way to share experiences and to express freely emotions and ideas. This activity will be carried out with the support of NGOs staff, the support of MdM team and the resources of the NGO Waay.

Time: 9th month/first year, first discussion groups taking place. Following, one session per month.

Beneficiaries: Each discussion group will have 40 attendees total per month. Total 480 per year.

Activity 4: Production and distribution of information documents.

As previously mentioned, the intervention wishes to produce and disseminate among all the key stakeholders friendly and easy information on different and most common mental health topics.
We have referred previously to a vast lack of knowledge that generates a spread stigma. Therefore, the choice to fill the gap of knowledge is already the first step to work better on anti-stigma initiatives.

Time: 10th month, first materials to be printed and distributed. Second round will be in the beginning of second year, end of second year, and beginning of third year.

Activity 5: Awareness sessions (for mental health hospitals staff, PHC centre staff, NGOs, community leaders, families and patients) on the rights to health care access.

Part of the anti-stigma initiatives is disseminating the concept of the right of the patient to receive health care whatever is his/her condition or disease. In this case, these sessions will take place when the intervention has started to be known in the community, and as well when the referral system actors are well aware of the needs of the most vulnerable population, in order to better express based facts realities and experiences to be brought as examples.
Some experts on this field will be invited to participate as speakers.

Time: end of first year.
Target groups: Community leaders, staff of health care centres, NGOs, families will attend from the end of the first year 4 sessions per year. Participants each session: 40. Total of 160 each year, 480 for three years.

Activity 6: Social research on the obstacles of Mental Health access
Before the implementation of the activities, a qualitative study will be conducted in the area of the planned intervention to assess the take in charge of people with mental distress by the communities and to identify the obstacles to a better integration of these vulnerable people in the community.

As said above, during the first month and half of the project, an anthropological research will be carried in order to deeply analyse the patterns for looking and reaching services within the community.
This research will definitely support and help the organization of the activities, and the initiatives within the community and will support in delineating the correct approach or direction to take in creating the advocacy strategy.
One researcher will be responsible of carrying out the research, under the supervision of MdM team. Moreover, the different health care centres staff and NGOs staff will support through their participation in interviews or focus group sessions.
The results of this research will be printed and shared.

Time: First trimester /first year.

Impact of the achievement of the objective on the beneficiaries

Result 1 will provide the necessary skills to the NGOs' staff to deal with the persons they are already taking care of, but it will surely strengthen not only their knowledge, but their know-how in dealing with very specific cases. NGOs will become part of the

referral system and they will activate the referral system in their community, through the communication with the health centres and the mental hospitals if needed, and with the key community leaders. Their role as civil society association will be stronger and more effective as they will represent the link between social and health services, which are basic needs in marginalized areas, where in general health services are not easily approached and used by the community.

Result 2 will impact either the target groups, the patients, their families, the entire community, and PHC centres staff.
In specific, the families of the patients (according to the specific vulnerable population targeted) will find a platform, or informal network, where to find the necessary support, to discuss about the obstacles in accessing care, in proposing solutions, and as well in finding counseling support for themselves. Their role will be important, as they will take part in debates and discussions around the rights to access mental health services and patients' rights, and they will represent a clear voice of the needs in this community health area.
Patients will benefit of self-help groups, supported by both NGOs and health care centres staff. The role of the patients/vulnerable groups in the action is not simply as services user, but the patient will be part of awareness campaigns and activities to fight the stigma around mental health issues.
In the anti-stigma campaign and activities, the beneficiaries will raise their voices and stories on their status, and on the needs for the society to activate itself, and the concerned governmental and non-governmental institutions, in adopting adequate policies to protect the right of each patient to receive a decent and dignitous mental health care.

An important anthropological research will be implemented by MdM before the beginning of the action, which will become a key element to help identifying the obstacles and common health patterns in the community. Beneficiaries and target groups will not only benefit of such a research but they will be part of it; such a process being part of their own rehabilitation.
Finally, objective 2 will help breaking the stigma around mental health, and it will able the target groups to find a supporting and understanding community and an effective health system around them, in order to reintegrate themselves as active citizens in their community.
Such a reintegration will be carried out with the support of all key actors involved in the action and first the patients themselves, through an holistic and comprehensive approach. In such approach, the health support by health staff or other specialized professionals will be integrated by educational or social support by the NGO staff and the community.

Objective 3: Effective and sustainable resources are allocated to implement efficient Mental Health policies

Result 1: An action plan is developed for advocacy

Activity 1: Definition of an Advocacy Action Plan
The intervention needs to be supported all along the process by advocacy action, to promote a deeper integration of the mental health services within the community and the primary health care system and allow an appropriation of this topic by all the stakeholders, and particularly by the authorities.

The assessment process, after discussions with key actors from the health system and civil society, allowed to define three target objectives that the advocacy action plan should work for their realization by the decision makers.

1/ Include psychiatric drugs in the essential drug list of the family health facilities;
2/Set-up a psychiatric department in the Health directorates of Cairo and Giza to improve the coordination and the integration of mental health services in PHC
3/Create a platform of state and non state actors working on MH care and patients' rights;
Nevertheless, after beginning of implementation of the project the objectives will be better clarified and agreed upon. The regular bi-monthly coordination meetings with all the stakeholders will help in reaching the final objectives and identifying the advocacy action plan for the remaining part of the project.
The above set advocacy objectives in fact clearly reflect the needs in this field:
Health care centres do not have psychiatric drugs; there is no active platform of experts, of patients, of families, of services providers involved in discussions and policies debates; and finally a specific psychiatric department at the level of health directorates does not exist, to function as as coordination body for the mental health programmes in the primary health care centres and the general secretariat of mental health.
In practice, the key stakeholders from the civil society NGOs, the MoHP, professionals, patients and their families will participate at 4 main workshops (the first year only 1), in order to discuss, prepare advocacy initiatives together.

Time: on the 6th month of the project the first workshop.
Target groups: Each workshop will be attended by around 30 participants.

Result 2: Reinforcement of the existing data collection system

Activity 2: Data collection about mental health in Primary Health Care centers, integrated in the existing data collection system.

Data collection is a necessary aspect in any project as generally data collection lacks in the system. In fact, it was underlined that data about mental health or any psychological distress are not collected in health care centres, maybe because of a lack of any mental health sheets. Therefore, it is important for any advocacy action to have collected data and analyse them, to have a clear image of the situation. The intervention wishes therefore to collect data, using the same existing data collection system of the health centre. The health care centre staff will have this role.

Time: from the 4th month of the action, follow-up every month.

Result 3: Promotion of a deeper integration of community mental health care in the health system

Activity 3: Organization of conferences on decentralization of Mental Health services and on community based approach.

As part of the advocacy initiatives of the intervention, two conferences will be organized with the objective to provide a space for learning from new experiences, for exchange of tools, materials and experiences, and for discussion on needs and solutions.
Ideally, the conferences will be organized at the end of each year of the project, in order to have enough time to prepare them well, to invite speakers, to prepare material.

Time: first conference end of 1st year; second conference end of 2nd year, 3rd conference at the end of last year.

Target groups: Representatives of the MoHP, of the NGOs, of community leaders, and other INGOs will attend the conferences. Each conference attendance will be: 100 participants.

Impact of the achievement of the objective on the beneficiaries

With the achievement of this result, which definitely includes the important advocacy aspect of the action, women victims of violence, people living with HIV/AIDS, children in street situation, children with disabilities and their families, will finally see recognized their "life problems" as a topic/condition that deserves technical and human support, specialized solutions and experts available. Psychiatric drugs will be available and provided under supervision of trained doctors, leading to a well organized rehabilitation system as any other physical health condition would require.

Professionals and experts in this field will have a "platform" to discuss, exchange and finding solutions on issues related to rights to mental health care access; these experts will have the possibility to share with the patients, their families and social professionals important issues related to health care obstacles.

Of course, key authorities like the Primary health care department and the General secretariat of mental health will be directly involved in this process; like the NGOs staff, they will guarantee the continuation and the sustainability of all the efforts of the action. A specific department of mental health will be located in the Health Directorates of Cairo and Giza in order to facilitate and coordinate mental health care programmes integrated in PHC centres.

Being part of the advocacy process together with relevant and solid group of volunteers professionals, mental health experts, patients and families, Egyptian authorities will have the chance to reinforce their constructive role in enhancing a comprehensive health system, and in the same time they will benefit from the pilot implementation of a decentralization process of mental health services in the community and primary health centres.

Target groups and final beneficiaries will learn from different community mental health programmes experiences coming from different contexts, and this will be an enriching experience in the lives and work approach of medical and social professionals in Egypt.

METHODOLOGY

Project management

Médecins du Monde general approach when implementing "health and development" interventions, targeting vulnerable and at risk populations is based on a participatory approach that implies a strong participation of all the main actors and stakeholders involved in the different parts of the project.

The partners will be involved with MdM team in the different project implementation phases: designing, carrying out, monitoring and evaluating of the project activities. Moreover, the project is structured to have an initial (first year) and intensive capacity building component in order to ensure that all the actors and beneficiaries receive master key concepts and skills on mental health thematic, and community health.

Health care centres staff, NGOs staff, and community leaders will be involved in receiving training sessions, and will be encouraged to disseminate the contents of the sessions among their medical and social colleagues, and among the community leaders through other sessions.

Afterwards, the capacity building component will reduce its intensity at the end of the second year, in order to focus further on the advocacy and anti-stigma initiatives. In general, for any advocacy action to work effectively and to have a longstanding impact, there is the need to create a fertile ground for actors to share a strong common vision on the objectives to be achieved and on the choice of specific activities to be used. The

first and second years will therefore focus as well in organization of workshop on advocacy concepts, on assessing the final advocacy objectives and to agree on the type of actions.

MdM team will have the main role of supervising the entire intervention together with the main partners, to provide technical support through its technical team, to monitor and evaluate the action together with the partners and to provide incentives for specific set of activities carried out by the partners.
MdM team will be composed by the following teams and functions:
A supportive team composed by an administrator, a logistician, two drivers and a cleaner.
A technical team composed by a mental health officer and a psychologist, an IEC (health education) officer, a communication and advocacy officer. This technical team will be supervised by a Medical coordinator.
The entire MdM mission will be managed by one general coordinator, helped by an assistant.

Roles of partners and stakeholders

NGOs
The six operational partners will have an active role in the implementation of the activities.
Each NGO will nominate one person in their staff who will be the field project manager/focal point who will have a specific job description. The field project manager will be recruited by the NGO partner and the supervision of his/her job will be carried out by the NGO and MdM general coordinator assistant; as well the NGOs will choose a person of their staff as focal point for the health education and anti-stigma activities.

The NGOs are part of the designing of the project, they will carry out the project activities, and they will be part of the monitoring and evaluation process.
In specific, the NGOs staff will be responsible in organizing the focus groups with their target populations in order to assess with MdM team, the needs in training for the staff of health care centres and the NGO.
In this part, one of the NGO partner, Waay, will have a more specific role with MdM team in organizing the results of the focus group in a set of training subjects for the health care centres (for medical and social staff), and as well a follow-up system for the training sessions.
The partners will as well support the “workshop for training needs” that will be organized in the first month of the project; they will help in providing the space and the logistics and inviting the participants.
On rotation bases, the NGOs will take the lead in organizing a bi-monthly coordination meeting, with the objective to share experiences, discuss and find solutions for challenges, and to prepare an advocacy action.
NGOs partners will as well collaborate with the health care centres in providing an health education programme on concerned issues related to mental health.
A very strong role will be the one of leading the anti-stigma initiatives, because of their reputation in their community, and the knowledge of the context and already experience in the field.
Finally, the NGOs will be responsible of all the activities and services to be provided within the community and in the health care centres, from the discussions groups to the patients, to the awareness sessions with the community leaders, and as well the participation in the anthropological research.
Partners NGOs will be finally participating in all the advocacy actions, sharing the objectives and the tools of the action.

Beneficiaries

The persons suffering of psychological distress will have a signficative role not only as services users in the NGOs or health centres, but as well in organizing and actively participating in the anti-stigma activities, within their community and at larger scale as well.
They will be part of the theatre experience, and they will be the ones, with the support of a theatre experts group, who will choose the stories to tell. They will also be part of a radio programme about their stories, accompanied as well by experts in this field.
Moreover, they'll be part of the advocacy action, bringing their stories and experiences and discuss with experts their needs.

Families of the patients will also find an active platform, where they will discuss with other families on obstacles in health access, propose solutions, and discuss as well policies and concerned laws. The families will have the possibility within their informal network to organize special activities for entertainment or education.

Target groups

The 7 health care centres staff, besides attending the training sessions, will have to disseminate the new knowledge and skills to their colleagues. Only this could guarantee that the training sessions will be adequately benefiting a good number of professionals, and that there is a continuation of the capacity building within the health centres.
Moreover, the staff of the health care centres will continue holding their weekly health education sessions but integrated with a monthly programme about mental health subjects, targeting the people of the community and with the help of the NGOs staff.

The institutional partners have a great role to play in the advocacy actions as they will guarantee the future continuation of the actions; therefore their active involvement not only in the advocacy, but in all the activities of the project is expected.
The Primary Health Care department will appoint two persons to follow-up all the activities related to the primary health care centres: the training sessions, the health education sessions; these persons will also take active part in the coordination meetings, and advocacy workshops.
The General Secretariat of Mental Health as well will appoint one person who will follow-up the activities carried out with the GSMH: he/she will support in finding a proper psychiatrist to make consultations once a week in the PHC centres; this person will as well coordinate and take part to the coordination meetings, will take part of the advocacy workshops and relevant advocacy activities.
Of course, an MoU will be signed between MdM and the MoHP concerned departments.

Communication

Working in partnership with different NGOs and other stakeholders requests to have a good and effective degree of communication among all the actors of the action, therefore the communication channels will be determined and agreed upon from the first meetings with the partners. Of course, the presence of an active and professional field project manager/focal point in each partner NGO will guarantee a good communication exchange, and as well it will guarantee a constant and smooth exchange of information and data, from the health centres and the NGOs in the community, MdM team and the institutional partners.

Within its communication strategy, the project will organize the following visibility actions and events:
Communication material to be distributed among all the actors, civil society, professionals and local authorities: posters, educational mental health material, final project brochure, one anthropological research, and an updated version of the mental health guidelines for PHC centres.

Events: three conferences on community mental health (end of first year, end of second year, and end of the project); the final project event which will be a show case of what has been done will also include a dissemination of the project results and main findings.

Monitoring and Evaluation

Monitoring

The internal monitoring of the project will be guaranteed by a collective and participatory monitoring set of tools that will support the measurement of the achievements of the indicators for each activity. This process will not only measure the activities indicators but as well the staus of partnership collaboration.
The monitoring set of tools will be designed and agreed upon and shared by MdM team and the partners team in the very beginning of the project, in order to know how to use it, and to set guidelines to help a smooth follow-up.
In practice, a steering committee will be set up and once a month, the partners will organize a monitoring meeting, and at the end of each semester, an evaluation session/workshop will take place to further focus on the results achieved, challenges encountered, modifications to apply. As well this workshop will hep to make a point on the partnership collaboration.

Evaluation

The monitoring system will help to measure the progress of the project activities, in order to have material to carry out a project evaluation.
A new evaluation tool in this project consists in is the setting up of a committee that will be composed by professionals and beneficiaries (not partners) who will supervise with a more external and objective eye that the project activities are in line with quality standards for training activities and with a clear improvement of the life of the intervention target groups. The presence of such external committee of experts and beneficiaries has the added value of having a more objective vision of the overall activities.
Moreover, the action foresees a mid-term and an external final evaluation of the project. An external consultant will be hired to carry out these tasks. The mid-term evaluation will help in assessing the process of the project implementation and to adapt and modify accordingly; while the final evaluation will be a global assessment of the action, on its strengths and weaknesses and it will make recommendations on how the involved actors can ensure the sustainability of a longstanding impact.

Resources

Human Resources:

1 general coordinator
1 medical coordinator
1 Psychiatrist
1 Psychologist
1 IEC officer
1 Advocacy/communication officer
1 general coordinator assistant
1 administrator
1 Logistician
2 drivers
1 cleaner
6 NGOs focal point
6 NGOs health education referents

Other sources:
1 local office and running costs
Equipment and supplies
Travel costs
Evaluation costs
Translation services
Conferences and seminars
Visibility actions
Incentives
Health education
Training

Sustainability, exit strategy and dissemination of results

Sustainability

Sustainability of the action is included in the carry-out and follow-up of the activities and it is also a key aspect that all the partners will focus at when implementing the activities in order to give the action an enduring impact in the future.

Aspects that will ensure the sustainability can be listed here:

Involvement of the concerned local authorities; they don't only have the will and belief in the objective of the project, but they also play an active role in all the advocacy activities, so that they will better own the project at its end. In specific, as they will be involved in the advocacy workshops, they will represent a strong chance for policies to be reinforced, applied or proposed, and finally for agreements and laws to be followed-up. In specific, the MoHP (Primary health care department, and General secretariat of mental health); the National Council of Childhood and Motherhood, the National Council of Women, the National Council of Mental health will be involved.

Participatory approach: the project wishes to adopt a participatory approach in all the phases of the project, in designing it, in monitoring and evaluating it, in carrying out the activities of capacity building and advocacy.
Moreover, participatory approach means involving target groups and beneficiaries, in specific the persons directly suffering of mental distress and their families, civil society organizations and finally the local authorities concerned. In this way they can feel part of and owners of the project.

The main components of the project will include a specific follow-up system, in order to guarantee a better evaluation. Such follow-up system will not only guarantee a good monitoring but as well it will help in guaranteeing the continuation of the activities.
For instance, regarding the capacity building, it will have an agreed upon follow-up system, through on the job training, and a ToT that will guarantee a continuation of the activities, at the level of nurses and social workers in health care centres.

At the level of advocacy, the continuation will be based on the active participation of the local authorities concerned. As mentioned earlier, the activation of networks of families, and the platform of experts, beneficiaries and representatives of local authorities will guarantee that the follow up of the actions or initiatives undertaken during the project will be continued, particularly to obtain changes in policies or to request renovation of agreements.

Financially, the project activities will not request a high budget, as capacity building should be included in the regular curricula of the medical students or in the primary

health care staff training; the advocacy actions in general do not request as much money as they request a high commitment and will to change the status of the present conditions.
Moreover, an adequate and regular dissemination of results at a wide level, and a strong communication strategy will ensure that the project advocacy will be replicated by other agencies already active in the field of health care access improvement of vulnerable populations.

Exit strategy

Regarding the activities of objective one:
Once the referral system is set-up, it will be kept activated and efficient by the supervision of the concerned departments of PHC and general secretariat of mental health. Such an activity will not request therefore any cost.
The training component as well will continue and other primary centres teams will be trained, through the organization of a ToT that will permit the staff of the 7 centres to become trainers and transfer knowledge to others.
After three years of consultations inside the centres by a specialized doctor in psychiatry, the project expects to have created a group of volunteers who will provide consultations for free, or for a symbolic fee.
Moreover, regarding objective one, the local governmental institutions will be involved from the beginning in the project activities, and this participation will make them owner of the activities, until include them in their normal routine work.

Regarding the activities of objective two:
Objective two involves the participation of the community, the families and the NGOs.
As above, the training component will be able to continue and the knowledge will be transferred to other NGOs, or more marginalized groups, through the provision of the ToT to the NGOs staff.
The discussion groups for the beneficiaries instead will be part of the routine work of the NGOs staff; in case the NGOs will need an expert, then a fee cost needs to be considered, and NGOs might look for support or to the MoHP, or to the platform of experts created and reinforced along the project, who will provide sessions, or training or consultations for symbolic fees.
The continuation of awareness and anti-stigma activities, they will simply need logistic costs, like rent of halls, breaks.

Regarding the objective three:
The activities are directly related to advocacy actions, which will be sustainable when all the governmental and non-governmental actors are involved and motivate in the actions. Therefore, this is a participatory process that will start from the beginning of the project. At the end of the project, such actions will need of basic logistic costs for meetings, and seminars.

Dissemination of results

At the end of the project, after the external evaluation has been carried out, the action final results, main findings and recommendations will be publicly disseminated. The content of the reports and results, integrated with testimonies and field experiences will be printed under the form of a brochure or booklet.
First of all, the results will be discussed at the level of all partners, non-governmental and governmental bodies, with the objective to identify the continuation of the activities and the responsible for each tasks. For instance, the families' network, with the support of the new platform of experts, could continue their sessions for self support, and for continuing the anti stigma and rehabilitation activities with and for the vulnerable groups.

Inside the health care centres, the MoHP will feel owner of this project and will continue the provision of training sessions for the doctors, as they will have now doctors who already attended these sessions and as well the training material, plus the mental health guidelines. While the nurses and social workers will have received ToT and therefore will be the ones transferring the information to their colleagues.
The NGOs can continue their training provision through the material received, and through the organization of sessions for their colleagues. Afterwards, at a wider level, the same results will be disseminated during the final closure event and last conference.
At the specific level of the partners, there will be a multiplier effect taking place, as the NGOs will have brought a change in attitudes towards people suffering of mental distress; health care centres will have the tools and knowledge to change attitudes and quality of services at work level, and as well inside their community.
Governmental bodies representatives will create the possibilities for changing in policies, and if policies or new methods of take in charge of mental health issues took place, then the local authorities will fight for their application and reinforcement.

Risk analysis and assumptions

Risk analysis and mitigation measures table

Considering the political and social instability of Egypt, we consider important to drive the attention on possible risks, related to the action proposed.
First of all, the political situation could deteriorate during the next period having as consequences if the project is already started: the decrease of the activities, due to lack of security, the closure of NGOs day care centres, the reduction of personnel in NGO or day care centres, lack of movements among NGOs or to NGOs, or day care centres.
In this case, the most important step is to avoid putting at risks people lives; in case there are no obvious dangers, the activities will keep a very low visibility, minimizing the movements and organizing the training sessions or meetings in secure place, close to the NGO or health care centre. If social-economic situation deteriorates, leading to strikes, occupations, religious type clashes, high prices inflations, or if criminality situation deteriorates and violence spread in the streets, then in this case, it means that the working hours will be reduced according to the risks and alarm.
Internal and external communication should increase and be accurate the highest are the risks. In the same time, movements should be reduced.

Main preconditions and assumptions during the implementation phase

For all the project activities, it is necessary for the action to take place smoothly. NGOs staff is always available to carry out the activities. This means that the board of the NGOs and directors need to be fully involved in decisions making level with MdM team.
The Health care centres team is always available; PHC department facilitates the necessary permissions for the team to attend training sessions and to provide themselves training sessions.
Communication channels are accessible to everyone involved in the action.
The actions might meet the following risks:
High turn-over of NGOs staff or Health care centres staff;
Security issues reducing the number of activities;
Big changes in the government, therefore the governmental counterpart in the project will not guarantee their presence neither their support, as the new ones will not know the project;
After the end of the project, and for a continuation of the project, the risks related to security remain unchanged.
The action would continue if:
Effective and strong communication method is present among all the partners;

High turn-over of staff (NGOs and health care centres) has been tackled by the concerned bodies;
Governmental bodies, local authorities have integrated the objective of the project among their key objectives.
Platform of experts is highly committed.

Logical Framework
File attached.

Budget
File attached

Work plan
File attached